Gray Davis, Governor
State of California
Business, Transportation and Housing Agency

980 Ninth Street, Suite 500
Sacramento CA 95814
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November 5, 2002

IN REPLY REFER
TO FILE NO: 933-0176

Mary V. Anderson, Regional Counsel
Aetna US Healthcare of California, Inc.
2409 Camino Ramon
San Ramon, Ca. 94583

RE: ROUTINE EXAMINATION OF AETNA US HEALTHCARE OF CALIFORNIA, INC.

Dear Ms. Anderson

Enclosed is the Final Report of the routine examination of the fiscal and administrative affairs of Aetna US Healthcare of California, Inc. ("Plan") for the quarter ended June 30, 2001, conducted by the Department of Managed Health Care ("Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1]

This final report includes a description of the compliance efforts included in the Plan's September 10, 2002 response, in accordance with Section 1382(c).

Section 1382 (d) states, "If requested in writing by the plan, the commissioner shall append the plan's response to the Final Report issued pursuant to subdivision (c). The Plan may modify its response or statement at any time and provide modified copies to the Department for public distribution no later than 10 days from the date of notification from the Department that the Final Report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 1 of Division 1 of Title 28, California Code of Regulations, beginning with Section 1300.43, and transferred to the Department of Managed Care pursuant to Health and Safety Code Section 1341.14.

date of the Plan's receipt of this letter. If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Report or wishes to modify any information provided to the Department in its response to the Preliminary Report, then please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

Ten (10) days from the date of the Plan's receipt of this letter, the Department will make the attached Final Report available to the public.

If there are any questions regarding this letter, please call.

Sincerely,

Elizabeth Phillips
Supervising Examiner
Division of Financial Oversight

Cc: Andrew Meyers, Acting Assistant Deputy Director, Office of Health Plan Oversight
Mark E. Wright, Chief, Division of Financial Oversight
Cathi Richards, Counsel
Salli Thompson, Principle Financial Officer, Aetna U.S. Healthcare of California
Shelley Tang, Examiner
Kelvin Gee, Examiner

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

AETNA US HEALTHCARE OF CALIFORNIA, INC.

FILE NO.: 933-0176

DATE OF FINAL REPORT: November 5, 2002

Examiner-In-Charge: Shelley Tang
Oversight Examiner: Elizabeth Phillips

BACKGROUND INFORMATION

Date Plan Licensed:	August 6, 1981
Organizational Structure:	Aetna U.S. Healthcare of California is indirectly a wholly-owned subsidiary of Aetna Inc.
Type of Plan:	Full Service Plan with commercial and Medicare enrollees. It has a Knox-Keene Point-of-Service product.
Provider Network:	Plan has contracting providers
Plan Enrollment:	879,507
Service Area:	Statewide
Date of last Public Report	December 23, 1997

FINAL REPORT OF ROUTINE EXAMINATION OF AETNA US HEALTHCARE OF CALIFORNIA, INC.

This is a Final Report of the routine examination of Aetna US Healthcare of California, Inc. ("Plan"), conducted by the Department of Managed Health Care ("Department") pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975[1]. The Department issued a preliminary report to the Plan on July 24, 2002. The Department received the Plan's response on September 10, 2002.

This Final Report includes a description of the compliance efforts included in the Plan's September 10, 2002 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the quarter ended June 30, 2001, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report. Please direct your response to Shelley Tang, Examiner, with this Department.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at division 1 of Chapter 1, Title 28, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET

BALANCE SHEET
As of June 30, 2001

	Balance Per F/S @ 6/30/01	EXAMINATION Adjustments & Reclassifications Debit	Credit	Balance Per Exam @ 6/30/01
CURRENT ASSETS				
Cash	$66,155,214			$66,155,214
Short-Term Investments	225,137,902			225,137,902
Premiums Receivable	72,875,422			72,875,422
Interest Receivable	3,027,909			3,027,909
Other Receivables ~ Net	10,986,777			10,986,777
Prepaid Expenses				
Aggregate Write-Ins ~ Current Assets	32,034,966			32,034,966
Total Current Assets	$410,218,190			$410,218,190
OTHER ASSETS				
Restricted Funds	$6,650,327			$6,650,327
Long-Term Investments				
Intangible Assets & Goodwill				
Leasehold Improvements - Net				
Aggregate Write-ins for Other Assets				
Total Other Assets	$6,650,327			$6,650,327
PROPERTY&EQUIPMENT				
Furniture & Equipment				
Aggregate Write-ins for Other Equipment				
Total Property & Equipment				
TOTAL ASSETS	$416,868,517			$416,868,517

BALANCE SHEET
As of June 30, 2001

	Balance Per F/S @ 6/30/01	EXAMINATION Adjustments & Reclassifications Debit		Credit		Balance Per Exam @ 6/30/01
CURRENT LIABILITIES						
Accounts Payable	$0.00					$0.00
Claims Payable	19,730,260			R1	12,597,580	32,327,840
Accrued Inpatient Claims (IBNR)	126,049,063	R1	12,597,580			113,451,483
Accrued Physician Claims (IBNR)	34,750,452					34,750,452
Accrued Other Medical (IBNR)	2,157,822					2,157,822
Accrued Incentive Pool	6,799,729					6,799,729
Unearned Premiums	30,023,458					30,023,458
Aggregate Write-ins	119,588,839					119,588,839
Total Current Liabilities	$339,099,623		12,597,580		12,597,580	$339,099,623
OTHER LIABILITIES						
Aggregate Write-Ins for Other Liabilities						
Total Other Liabilities	-					-
NET WORTH						
Capital	250					250
Paid In Surplus	78,852,906					78,852,906
Unassigned Surplus	(2,050,216)					(2,050,216)
Aggregate Write-Ins for Other Net Worth Items	965,954					965,954
TOTAL NET WORTH	$77,768,894					$77,768,894
TOTAL LIABILITIES AND NET WORTH	$416,868,517		12,597,580		12,597,580	$416,868,517

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
QUARTER ENDED JUNE 30, 2001

	Balance Per F/S QE 6/30/01	EXAMINATION Adjustments & Reclassifications Debit	Credit	Balance Per Exam QE 6/30/01
REVENUES				
Premium	$342,705,741			$342,705,741
Medicare	76,419,670			76,419,670
Interest	3,123,277			3,123,277
COB & Subrogation	3,037,713			3,037,713
Aggregate Write-Ins Revenues	396,417			396,417
Total Revenues	$425,682,818			$425,682,818
EXPENSES				
Medical and Hospital Expenses	$378,586,976			$378,586,976
Administrative Expenses	50,688,350			50,688,350
TOTAL EXPENSES	$429,275,326			$429,275,326
INCOME (LOSS)	$(3,592,508)			(3,592,508
Provision for Taxes	(96,480)			(96,480)
NET INCOME (LOSS)	$(3,496,028)			$(3,496,028)

SECTION I-a. EXPLANATION OF EXAMINATION RECLASSIFICATION

R1	IBNR	12,597,580	
	Claims Payable		12,597,580

To correctly state the Claims Payable balance. This matter is discussed in Section IV.

Section II. CALCULATION OF TANGIBLE NET EQUITY ("TNE")

Net Worth per Examination @ June 30, 2001 (from Section I.A)	$77,768,894
Less: Non –Current Receivables from affiliate	(15,957,095)
Less: Intangibles	
Tangible Net Equity	$61,811,799
TNE required by Section 1374.64 at June 30, 2001	(53,243,505)
Excess Tangible Net Equity at June 30, 2001	$8,568,294

At June 30, 2001, the Plan was in compliance with the Tangible Net Equity requirements of Section 1374.64. No response was required.

Section III. COMPLIANCE ISSUES

A. FINANCIAL VIABLILITY

Section 1375.1 requires every licensed plan to demonstrate that it has a fiscally sound operation and adequate provision against the risk of insolvency. Rule 1300.75.1 requires that every plan demonstrate fiscal soundness and assumption of full financial risk through its history of operations, projections, provide for the achievement and maintenance of a positive cash flow, including provision for retirement of existing and proposed indebtedness, and adequate working capital, including provision for contingencies.

Our examination, plus our review of the Plan's financial statements filed with this Department during the past two years, disclosed that the Plan does not have a financially sound operation, as required by Section 1375.1 and Rule 1300.75.1. The Plan has experienced continuous losses, in total ($54,496,088) in the two years ended December 2001, and an additional loss of ($11,892,509) in the quarter ended March 31, 2002. The Plan's medical loss ratio averaged 94.26% for the quarter ended June 30, 2001 through the quarter ended March 31, 2002.

The Plan was required to submit a detailed Corrective Action Plan ("CAP") that addresses the Department's concerns regarding the Plan's ability to remain a financially viable business. The CAP should include specific management initiatives, the impact on

earnings associated with each initiative, time frame for implementation, management position responsible for implementation, and a description of the criteria the Plan will use in determining whether each initiative achieves its goal. The CAP should also include management initiatives to address the issue of medical utilization management.

The Plan responded by stating that its management team has developed a Corrective Action Plan ("CAP") to address financial viability. This CAP includes specific management initiatives, including medical utilization management initiatives, and projected impact on earning, timeframe, responsible parties, and criteria for evaluation.

The Plan was also required to submit financial projections in a format consistent with the financial statements submitted to the Department, on a monthly basis, for at least a one-year period or until the Plan reaches break-even point for one quarter, whichever is later, and also quarterly projections for one additional year. These projections should include a balance sheet, statement of revenue and expense, and statement of cash flows prepared in accordance with Generally Accepted Accounting Principles (GAAP). They should also include enrollment information, listing separately the enrollees transferred from Prudential, and TNE calculations (to include the calculation of the required amount of TNE). These projections should be accompanied by all assumptions which are necessary to support the projections. They should begin with, and agree with, the June 30, 2002 financial statements filed with this Department.

The Plan responded by providing projections. Regarding the Department's request to list Prudential enrollees separately, the Plan noted that the full service health care service plan Prudential membership moved to Aetna products on or before 12/31/01, therefore there was no activity related to Prudential enrollee movement for the forecast.

The compliance efforts described above are responsive to the deficiency cited. The Department understands from the Plan's response that the Plan is in the middle of a financial turnaround. As a result, the Plan is required to file a Progress Report with the Department at each quarter end until directed to discontinue. It should be filed as a "Quarterly Other" report with the routine quarter-end financial filing, beginning with Quarter- end September 30, 2002.

B. CLAIMS REIMBURSEMENT

Section 1371 requires a full service plan to reimburse claims within forty-five (45) working days after receipt of the claim, unless the claim is contested or denied by the plan. Section 1371 also requires that if the claim is contested by the plan, the claimant shall be notified, in writing, that the claim is contested, within 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Our examination disclosed that out of total claims processed from January 1, 2001 to January 18, 2002, approximately 3% of claims were adjudicated beyond the forty-five

(45) working days allowed by Section 1371**.** Furthermore, our examination disclosed that of the 160 claims selected by examiners, 50 claims were processed beyond the statutory time allowed.

The Plan was required to submit a description detailing the Corrective Action Plan the Plan has implemented to ensure compliance with Sections 1371 and 1371.35. The Plan was required to include procedures for monitoring compliance with Sections 1371 and 1371.35 and provide the management position that has the responsibility for implementing the Corrective Action Plan, and also ongoing compliance with these Sections.

The Plan was also required to include procedures that will ensure that the deficiencies in Section III, Paragraph B through F are corrected, and a system of monitoring has been implemented that will ensure that such deficiencies will not occur in the future.

The Plan responded that it had established numerous initiatives to ensure the timely adjudication of claims as listed below. Management positions responsible for each action item are noted:

- Established key performance indicators for claims turn-around-time that are more stringent than regulatory requirements (Goal = 90% of claims adjudicated within 30 days, with 80% of claims adjudicated within 5 days). Performance is monitored on a daily, monthly, and quarterly basis. Responsible manager = Claims Managers.

- Conducted root cause analysis to determine primary reasons for untimely adjudications of claims. Responsible manager =Claims Managers.

- Implemented "Big 3/Big 4" program in Customer Services, which allows customer service representative to reprocess certain types of rework claims generated by phone calls. This allows more timely adjudication by eliminating the need to forward such calls to the Claims department. Responsible manager = Member Services and Claims Managers.

- Implemented First Claims Call to Closure program, which involves proactive calls to internal department and/or the submitting provider in order to provide more timely and effective resolutions of claims. Responsible manager = Claims Manager.

- Developed Full Service Team program, which involves creating "teams" that include both customers service and claims specialist dedicated to one plan sponsor. This team approach reduces handoffs between internal departments, resulting in more timely adjudication of claims. Responsible manager = Member Services and Claims Managers.

- Increasing electronic submission and auto-adjudication of claims. Responsible managers = Provider Relations Managers and Claims Managers.

The compliance efforts described above are responsive to the deficiency cited.

C. PAYMENT OF INTEREST

Section 1371 further states that if an uncontested claim is not reimbursed within the forty-five (45) working day period, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the forty-five (45) working day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar ($10) fee.

Section 1371.35 applies to claims for emergency services. If an uncontested claim is not reimbursed by delivery to the claimant's address of record within the respective 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of fifteen percent (15%) per annum beginning with the first calendar day after the 45-working-day period.

- Our examination disclosed that prior to 1998 the Plan paid interest on uncontested claims that were paid later than forty-five (45) working days after the receipt of the claim, (including claims resulting from emergency service) only following a written request by the provider.

- Our exam further disclosed that, after 1998, when the system allowed for interest payments to be paid without the provider first requesting it, the interest payment was not always paid when due. In determining whether interest was due the system calculated the number of days from the date the claim was received to the last date the claim was handled by a processor. However, the claim may not have been paid on that date, but at a later date. Interest may not have been due when the processor last handled the claim, but was due when the claim was finally paid.

- Our examination also disclosed that some claims are initially paid at a compensation rate lower than required by the provider's contract, and when this is corrected an additional payments made to the provider, no interest is paid on that additional portion even though interest is due.

The Plan was required to identify all claims, and portions of claims, paid since January 1, 1996 on which interest should have been paid and, if interest has not been paid, pay that interest. This should include those claims, or portions of claims, that were originally denied but later paid.

The Plan responded by stating it is undertaking a review of all claims meeting these criteria and the estimated time of completion for an initial review is September 16, 2002. At that point in time, the Plan stated it would like to schedule further discussion with the Department to delineate appropriate required actions, particularly with regard to certain claims prior to January 1, 2001 and claims with de minimus interest underpayments.

The Plan submits that it is not appropriate to require re-adjudication of claims submitted by contracted providers prior to January 1, 2001. Contracted providers have specific contractual remedies, mutually agreed to by the Plan and the provider, in the event the providers believes a claim has been underpaid. Moreover, prior to 2001, there was no express statutory requirement that interest be automatically included on complete claims paid later than 45 working days from receipt. Nor was there industry consensus over whether contractual payment to providers were considered "claims".

Effective January 1, 2001, Senate Bill 1455 amended, Health & Safety Code 1371, to add language requiring the automatic payment of interest stating:

> "A health care service plan shall automatically include in its payment of the claims all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount."

The Plan asserts that its claims procedures were consistent with the requirement of earlier versions of Health & Safety Code 1371

The Plan's response is not responsive to the deficiency cited. Again, the Plan is required to identify all claims, and portions of claims, paid since January 1, 1996 on which interest should have been paid and, if interest has not been paid, pay that interest. This should include those claims, or portions of claims, that were originally denied but later paid.

This matter has been referred to the Office of Enforcement for administrative action.

D. UNDERPAYMENT OF CLAIMS

Our examination disclosed that during a two to three month period in 2001 a number of claims were underpaid due to a systems problem. (This was in addition to those underpayments described in Section III.C.)

Each underpayment occurred because the claims system erroneously determined that a claim payment made **earlier** to certain providers had been made in error. To rectify this, to recoup the overpayment, the system reduced the payment on a **later** claim to that provider. This was, of course, an adjustment that should have not been made.

The Plan stated during our examination that the system problem had been fixed, but the

providers had not all been reimbursed for these reductions in claims payments.

The Plan was required to state the date on which all reimbursements were made to providers whose claim payments were effected by this systems problem. The Plan was reminded that interest payments required by both Section 1371 and 1371.35 should be included.

The Plan responded by stating that letters were mailed to affected providers on December 10, 2001 explaining the issue and advising them that all reimbursement, including interest, would be made by December 21, 2001.

The Plan's response does not respond to the cited deficiency in that the Plan did not state the date by which all reimbursements were made to providers whose claim payments were effected by this systems problem. The response merely stated that the providers were told that they were to be paid by December 21, 2001. In your response please confirm that the providers were indeed paid by that date.

E. REIMBURSMENT OF CLAIMS OVERPAYMENTS

Section 1371.1 states, in part, that prior to a provider reimbursing a plan for an overpayment of a claim the plan should notify the provider in writing and the provider should have the opportunity to contest the reimbursement.

As noted in Section III.D. the Plan, on occasions, requires providers to reimburse overpayments of claims. Although Section III.D. describes a situation that occurred in error, it is important that the Plan have policies in place for handling the reimbursement of overpayments which is in compliance with Section 1371.1.

Our examination disclosed that the Plan does not provide a notice to a provider that is required to make a reimbursement of an overpayment. Instead, we found that the Plan merely deducts the overpayment from a later claims check.

The Plan was to provide a copy of the policy, that has been implemented, that will ensure that when a provider is required to reimburse the Plan for a claim overpayment, the request for the reimbursement will be handled in compliance with Section 1371.1

The Plan responded by including a copy of the policy that includes provider notification of overpayments and opportunity to contest the reimbursement request. This policy is followed for overpayments of fee for service claims. The workflow process for recoupment of overpayments to capitated IPAs and medical groups was included and also a sample provider letter.

The compliance efforts described above are responsive to the deficiency cited.

F. CLAIMS REIMBURSEMENT FOR OUT-OF-AREA EMERGENCY CLAIMS

Section 1371.4(b) provides that "[a] health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee…." Billed charges should be reimbursed in full unless an arrangement exists between the Plan and the non-contracting provider to allow for a discounted payment.

Our examination disclosed that the Plan pays claims to non-contracting providers (i.e. those claims related to out-of-area emergency services), at less than 100% of billed charges.

Billed charges should be paid in full unless an arrangement exists between the Plan and non-contracting provider to allow for a discounted payment. Denying a portion of the claim may result in the provider making a claim against the enrollee.

The Plan was required to review all claims paid to non-contracted providers since December 31, 2000 where the Plan reimbursed the non-contracted providers less than 100% billed charges. The Plan should then determine if the enrollee was billed by the non-contracted provider, and subsequently paid, the denied portion of the claim. The Plan should then reimburse the enrollee or provider, as appropriate, for that amount. Furthermore, interest should also be paid to the provider or enrollee if required by Section 1371.35(b). The Plan was required to state the date on which all payments have been made. Also, give assurance that in the future, all claims paid to non-contracting providers will be paid at billed charges unless arrangements have been made with the provider to pay at a discounted rate.

The Plan responded by stating that it disputes that the Knox-Keene Act required it to reimburse non-contracting providers for 100% of their billed charges. The Plan does acknowledge that it must assure that members are held harmless for any expenses incurred in connection with their receipt of out of area emergency services.

The Plan continued that in the event a member has paid for out of area emergency services and seeks reimbursement, the Plan reimburses the member for the full amount the member has paid, less any applicable co-payment. In the event a provider attempts to collect for out-of-area emergency services from a member, the Plan takes steps necessary to assure that the member is held harmless for such claim. The Member Handbook says on page 21, under the section "If you receive a bill":

> " However, if you do receive a bill for covered services, send a copy of the itemized bill with your identification number clearly marked to us at the address on your ID card."

Additionally, Customer Service Representatives have instructions to have a non-par provider claim reprocessed at billed charges if a member is being balance billed.

The Plan asserts that it has a right to pay appropriate claims for out-of-area emergency services at a reasonable and customary rate, or to negotiate the amount of payment with such a provider, so long as the member is held harmless from the charges. The Plan may also be able to use other contractual rates for these providers through arrangements with its affiliates. Additionally, because of a small number of providers who attempt to submit excessive charges in these situations, a requirement to reimbursement charges as billed could encourage excessive or fraudulent fees.

In developing this position, the Plan has relied on statements made by health care services plan regulators within the Department of Corporations, as well as statement made by Department of Managed Health Care officials in connection with the information gathering activities of the Department in its drafting of the proposed regulations on Claim Settlement Practices and Dispute Resolution Mechanism.

Specifically, the Plan refers to a September 24, 1999 letter from Steven Goby, Corporations Council, Department of Corporations, a copy of which was included with the response: DOC Questions and Answers for Western Claims Conference Delegates. Question 3 on page 1 asks:

> "How should non-contracting providers be reimbursed? At 100%? Usual and customary?

The DOC guideline answer:

> "…The [Knox-Keene] Act does not specify rate of payment for non-contracting providers."

The Plan also notes that in both the public hearings on the above-referenced regulations and in Department sponsored focus groups, there has been significant discussion about the appropriate reimbursement rate for out-of-area emergency services.

Finally, the Plan stated that given the Plan's clear reliance on Department statements and the Plan's commitment to holding members harmless in the event they are billed for out of area emergency claims, the Plan submits that its practices are not deficient and respectfully requests that Item F be removed from the Final Report.

The compliance efforts described above are responsive to the deficiency cited except that the Plan is required to provide, in its response, assurances that all payments made to non-contracting providers are fair value for the services provided.

G. LISTING OF PENDED CLAIMS

Section 1300.77.4 states, in part, that every plan shall institute procedures that permit the determination of the date of receipt, the status, and the dollar amount of pended claims.

Our examination disclosed that the Plan's list of Pended Claims included claims received between 1996 to 2000. The Plan stated that these claims had been adjudicated, but were unable to provide any evidence that this was so. The Plan further stated that there appeared to be a systems problem that had previously not been identified and hence had not been corrected.

The Plan was required to provide evidence that the claims received from 1996 to 2001 on the Pended Claim List reviewed by our examiners have now been adjudicated. Also, the Plan was required to provide assurances that the system problem that created this deficiency has been corrected.

The Plan responded by stating that all claims on the 1996-2001 Pended Claims list have been adjudicated. Copies of checks for the samples of claims reviewed by the Department were included with the response. Also, the Plan included a Claims Report run as of September 7, 2002 showing that there were no remaining pended claims with dates of services between 1996-2001.

The Plan also stated that it had discovered that a systems error prevented some claims from being assigned to service centers for processing. This problem has been addressed.

The compliance efforts described above are responsive to the deficiency cited.

H. RESTRICTED DEPOSITS

Section 1374.68(a) requires that a plan that sells a point-of-service product maintain a deposit that has a fair market value equal to the greater of $200,000 or 120% of the plan's current monthly claims payable plus incurred but not reported balance for out-of-network coverage for services provided under point-of-service contracts.

Our examination disclosed that at June 30, 2001 the Plan's deposit assigned to the Director of the Department of Managed Health Care was insufficient as required by Section 1374.68(a). The required deposit was $15,513,072 while the balance maintained by the Plan was $6,650,327. The Plan was deficient by $8,862,745.

The Plan was required to provide evidence that the Plan is now in compliance with the requirements of Section 1374.68(a) and to provide a copy of the instrument and the original assignment form that demonstrate that the balance of the restricted deposit is sufficient to be in compliance with Section 1374.68(a).

Also, the Plan was required to provide detail of procedures implemented to ensure that the Plan will maintain a sufficient deposit to be in compliance with the requirements of Section 1374.68(a) at all times. Also provide the management position responsible for the ongoing monitoring of the Plan's compliance with this Section.The Plan responded by stating that it will modify the calculation of the restricted deposit to comply with guidance received by the examiners for the September 30, 2002 quarterly filing. The

prior calculation was based on guidance from the 1996 Department of Corporation exam, which interpreted the regulatory wording "monthly claims payable" to mean "monthly expense". It is now our understanding that the current interpretation is that this should represent the liability balance rather than one month's expense. The resulting restricted deposit balance will be increased to $16 million. The Principle Financial Officer will be responsible for on-going monitoring of the Plan's compliance.

The Plan stated that it is in the process of purchasing additional restricted assets and will forward the Department's requested documentation on or before September 30, 2002.

The compliance efforts described above are responsive to the deficiency cited.

I. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. This includes sufficient staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

In order to demonstrate adequate administrative capacity, a plan must have an executive staff and support staff, which is properly dedicated to performing the necessary functions of a health care service plan. While a plan may enter into administrative service agreements with an affiliate or another company to purchase non-discretionary, ministerial services, the functions that require the exercise of any judgment or decision-making must be performed by Plan management. In addition, the responsibility for the day-to-day functions and the oversight of any delegated functions must reside with Plan management.

Section 1371 and Section 1371.35 (f) state that the obligation of the plan to comply with this Section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

Our examination disclosed that the Plan does not comply with the administrative capacity requirements of Section 1367(g) and Rule 1300.67.3, as demonstrate by the following:

1. Our examination disclosed that the Plan provided **no oversight** over delegated plan operations. For example:

    - During a walk-through of the claims department in Fresno, our examiners were told that claims data was input to the system at a location in Pennsylvania. However, when our examiners visited that location they discovered that claims were imaged at that location, but no input was performed. It can therefore be concluded that the Plan was providing no oversight over the functions performed in Pennsylvania because they were unable to identify the function being performed.

- The Plan was unaware that non-employees located in Ghana, Africa, and Mexico perform claims data entry functions. The Plan had delegated this function to its parent without implementing any oversight procedures, evidenced by the fact that the Plan's Claim Director was unaware of these worldwide arrangements.

2. Plan personnel were not responsive to our examiners' request for documentation to support the Plan's contention that claims on a current Pended Claim list that had been received between 1996 and 2000 had, if fact, been adjudicated, and should not be considered as "pended". Our examiners brought this matter to the attention of Plan personnel in March 2002, and followed this with additional requests which were all ignored until the Plan received an Interim Preliminary Examination Report three months later. This lack of response indicates a lack of administrative capacity in that it is the Department's expectation that when a potential problem is identified in the claims system the Plan will give the matter its prompt attention.

3. Our examination disclosed a further lack of administrative capacity in that some claims were overpaid, and although the Plan was aware of this matter, modification of the system to avoid this had not been implemented. The overpayments appear to occur because claims processors are required to make certain compensation rate determinations because the system is not fully automatic. Errors result because processors are not sufficiently trained and/or appropriate internal audit controls are not in place.

The Plan was required to provide a Corrective Action Plan that will provide for the implementation of policies and procedures that ensure the following:

- Each of the Plan's delegated claims processing activities that have been delegated will be supported by a written agreement that has been approved by this Department. Furthermore, such agreements will describe oversight procedures to be performed by the Plan. See Section III-J for related comments.

- Any potential problem in the claims processing and payment system will receive the Plan's prompt and immediate attention. See Section III-B, C. D and G for additional claims system problems noted in our examination.

Also, the Plan was required to provide the management positions responsible for providing ongoing monitoring of the policies and procedures described by these Corrective Action Plans

The Plan responded by stating that it respectfully disagrees with the Department's assessment of its administrative capacity, as follows:

The Plan does not consider the arrangement between the Fresno, Ca. office and the Blue Bell, PA office to be a delegated arrangement. The services are provided by the parent company through an administrative services agreement pursuant to which the parent company provides "information and technology management services and systems …to track process and support claims and capitation."

2. The Plan also stated that it would like to clarify that requests made by the Department were not "ignored"; there was frequent communication between Aetna staff and the Department during the audit period. The reason reports could not be produced in a timely manner was due to the fact that the most of this data is archived and systems limitations prevented timely retrieval and not because the Plan ignored Department requests.

The Plan further stated that it respectfully requests that the first two deficiencies be deleted from the Final Report.

With respect to the Required Actions the Plan responded:

The Plan will revise its administrative services agreement with its parent to provide for more specificity regarding the claims support systems as further discussed below.

The Plan's Claims Managers will assure that any potential problems in the claims processing and payment systems will receive the prompt and immediate attention.

Claims Managers will escalate issues as needed to the parent company's National Claims and/or Information Technology department as necessary.

The compliance efforts described above are not responsive to the first of the three deficiencies cited, in that the Plan appears to be unaware that it must remain responsible for oversight of services that are provided by another entity through contract. Furthermore, if these services have been sub-contracted by that entity, the Plan still has responsibilities for ensuring that the services are adequate. In your response provide assurances that the Plan will provide oversight over all administrative services that are being received through contracted arrangements.

J. AMENDMENTS/MATERIAL MODIFICATION TO PLAN APPLICATION

Section 1352(a) and (b), and Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the Commissioner within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Material changes to the Plan's operations are required to be filed as a Notice of Material Modification thirty (30) days prior to any changes being implemented as specified in this Section and Rules.

1. Our examination disclosed that claims imaging has been delegated by the Plan to its parent, Aetna Health Management, Inc. however, these arrangements are not described in the administrative service agreement between the Plan and Aetna Health Management, Inc.

2. Our examination disclosed that two entities, Datamark and ACS are performing data entry services associated with the processing of Plan claims. However, the Plan does not have an administrative service agreement with either of these entities.

The Plan was required to state the date on which an amended administrative service between the Plan and Aetna Health Management, Inc. was filed with this Department.

The Plan was also required to state the date on which administrative services agreements between the Plan and Datamark and the Plan and ACS were filed with this Department. The agreements should describe the services, terms of the arrangements and manner in which the Plan will provide oversight, and should be filed as amendments to the Plan's license application to the Department as follows:

The Department of Managed Health Care
Attn: Filing Clerk
980 Ninth Street, Suite 500
Sacramento, CA 95814

The Plan responded by stating the current Administrative Service and Solicitation Agreement between the Plan and its parent, Aetna Health Management, Inc. has been in effect since January 1, 1995. The Plan acknowledges that this agreement has gradually become outdated by changes in technology and an evolution in support needs and stated that it will undertake a comprehensive review of the Administrative services and Solicitation Agreement and new or revised administrative service agreement for the Department's review by the end of 4th quarter 2002.

During the week of September 2, 2002, the Plan will file with the Department a copy of the Master Professional Service Agreement between Aetna Service Inc., and ACS-Business Process Solution, Inc. (ASC), pursuant to which claims imaging and certain data keying services are furnished to the Plan. Additionally, the Plan is in the process of having the performance of these subcontracted services moved to the ACS facility in Garden Grove, California to facilitate Plan oversight of these functions.

The compliance efforts described above are responsive to the deficiency cited.

K. INSURANCE ISSUES

1. FIDELITY BOND

Rule 1300.76.3 requires that each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. Furthermore, it shall provide for thirty (30) days' notice to the Director of the Department of Managed Health Care prior to cancellation.

Our examination disclosed that the fidelity bond policy did not provide exclusive coverage. The policy included the Plan's ultimate Parent and its affiliates as named insured and contained an annual aggregate limit of coverage. The combination of other insured entities

and an annual limit could result in coverage being exhausted by claims made by other covered entities, leaving the Plan with no coverage.

This was a repeat deficiency and was also noted on the Department's Confidential Report dated August 11, 1997, which was issued following the Routine Examination of the Plan's books and records**.**

During the exam, the Plan provided evidence that it had obtained fidelity bond coverage that complies with Rule 1300.76.3. Therefore, no response was required.

2. MALPRACTICE INSURANCE

Rule 1300.51(d), HH-6-a requires evidence of adequate insurance coverage for claims for damages arising out of furnishing health care services (malpractice insurance).

Our examination disclosed that the malpractice insurance did not provide exclusive coverage. The policy included the Plan's ultimate Parent and its affiliates as named insured and contained an annual aggregate limit of coverage. The combination of other insured entities and an annual limit could result in coverage being exhausted by claims made by other covered enteritis, leaving the Plan with no coverage.

This was a repeat deficiency and was also noted on the Department's Confidential Report dated August 11, 1997, which was issued following the Routine Examination of the Plan's books and records**.**

During the examination the Plan provided evidence that it had obtained malpractice insurance coverage and now complies with Rule 1300.51(d) HH-6-a. Therefore, no response was required.

Section IV. OTHER ISSUES

A. FINANCIAL STATEMENTS REPORTING-REPORTING #4 ENROLLMENT

Our examination disclosed that the Plan has not been reporting enrollment additions and terminations.

The Plan was required to provide assurance that in the future enrollment additions and terminations will be reported on Report #4 of the financial statements submitted to the Department in the HMO Annual Reporting Form ("Orange Blank") filed with this Department.

The Plan responded by stating as of June 30, 2002 quarterly statutory filing, the Plan began reporting additions and termination on Report #4 that the Department has the Plan's assurance that it will continue such reporting in the future.

The compliance efforts described above are responsive to the deficiency cited.

B. CLAIMS PAYABLE

The Instructions to the Orange Blank, require that those claims that have been received but not paid be reported on Report #1 Part B, Line 2.

Our examination disclosed that the Plan calculates the balance of claims payable by allocating a percentage (10.8%) of total claims liability as claims payable. This method of calculating claims payable is not acceptable in that it does not reflect the inventory of claims received and not paid at the balance sheet date. Furthermore, our examination revealed that the Plan understated its claims payable by $12,597,580.

The Plan was required to provide assurances that in the future Claims Payable, reported on Report #1-Part B line 2 of the Orange Blank, will reflect an estimate of the liability related to the inventory of claims that have been received but not yet paid at the balance sheet date. Also, the Plan was required to provide the management position that will be responsible for ensuring ongoing compliance with this requirement.

The Plan responded by stating that as of June 30, 2002 quarterly statutory filing, the Plan changed its methodology for classifying claims payable to comply with the Department's preferred methodology and the Department has the Plan's assurance that we will continue such reporting in the future. The Principle Financial Officer is responsible for ensuring compliance with this requirement.

The compliance efforts described above are responsive to the deficiency cited.

C. NON-ROUTINE EXAMINATION

The Plan is advised that the Department will conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382(b).

No response was required to this Section.

2409 Camino Ramon
San Ramon, CA 94583

Mary V. Anderson
Aetna Health of California Inc.
(formerly Aetna U.S. Healthcare of California Inc.)
Law & Regulatory Affairs
(925) 543-8101
Fax: (925) 543-8105

November 18, 2002

Sent via E-mail and U.S. Mail

Shelley Tang, Examiner in Charge
Department of Managed Health Care
Division of Financial Oversight
980 9th Street, Suite 500
Sacramento, CA 95814

Re: Response to Routine Examination of
Aetna U.S. Healthcare of California Inc.

Dear Ms. Tang:

Reference is made to your letter of November 5, 2002, received by the Plan on November 8, 2002, containing the Department's Final Report of the routine examination of the fiscal and administrative affairs of Aetna Health of California Inc., formerly Aetna U.S. Healthcare of California, Inc. (the Plan) for the quarter ended June 30, 2001. The Plan wishes to modify the information provided to the Department in its September 9, 2002 Response to the Preliminary Report. Please include the following modifications in, or alternatively, append this letter to, the Department's Final Report.

The Plan has taken the appropriate steps to address all deficiencies found in the California Department of Managed Health Care's Final Report of the routine examination conducted in the second quarter of 2001. We are committed to continually improving the quality of service we provide to our members, providers and customers, and appreciate the feedback provided in this report.

Section A. Financial Viability

As stated in the 3rd Quarter 2002 Progress Report (filed with our routine 3rd quarter Financial Filing), the Plan has reported a second consecutive quarter with positive net income. These earnings are in line with the Plan's expectations that it has appropriately priced its business as necessary to cover its medical and administrative costs and achieve a reasonable level of income. This trend of profitability is expected to continue.

Shelley Tang, Examiner in Charge
Department of Managed Health Care
November 18, 2002 -2-

Section C. Payment of Interest

The Plan is developing a Corrective Action Plan to identify claims and portions of claims where interest or additional interest should have been paid. The Plan believes this represents a small fraction of overall claims and will work with the Office of Enforcement towards an acceptable resolution of this deficiency.

Section D. Underpayment of Claims

The Plan confirms that reimbursements, including interest, were made to affected providers on or before December 21, 2001. Additional documentation of these payments was sent to you via UPS delivery.

Section F. Claims Reimbursements for Out-of-Area Emergency Claims

In addition to the written response and documentation provided in our September 9, 2002 response, the Plan wishes to include our assurance that all claims payments made to non-contracting providers are fair value for the services provided.

Section I. Administrative Capacity

The Plan will provide additional oversight of delegated administrative, claims processing and payment functions performed by its affiliate under its Administrative Services Agreement. The Plan's Delegation Committee, which reports to the Plan's Board of Directors, will assume responsibility for monthly review of the performance and quality of these delegated functions. Currently this Committee is charged with monitoring and oversight of services delegated to provider groups and other Knox-Keene licensed entities. We believe that the Committee has the structure and experience to provide meaningful oversight of administrative services performed for the Plan by its affiliates.

Thank you for the opportunity to present these responses to the Department's Final Report.

Sincerely yours,

Mary V. Anderson